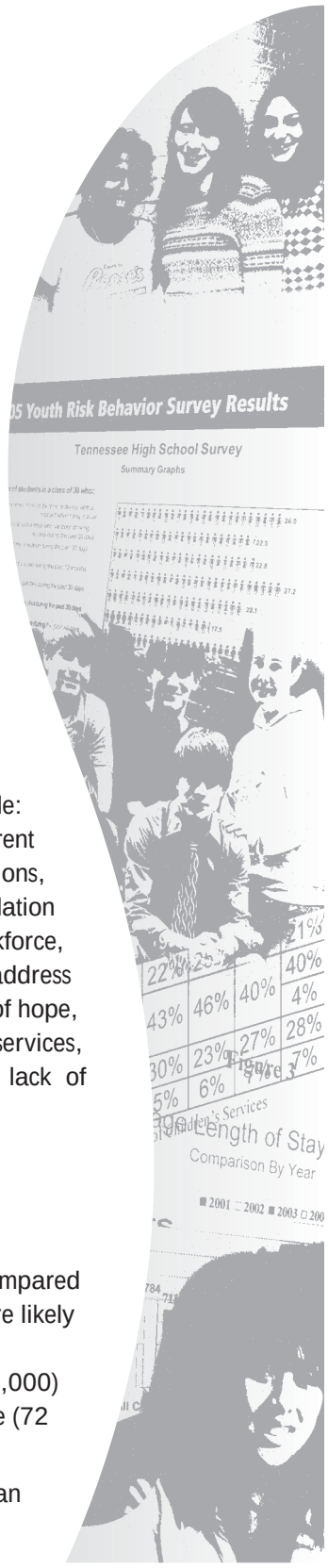
Chapter XII

Health Disparities Among Youth and Young Adults

Chapter Preview

This chapter includes a description of:

- Health disparities definition
- Health disparities among youth
- National and state data
- Best practices in eliminating health disparities
- State programs that address health disparities



The National Institutes of Health defines health disparities as the "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." Populations currently experiencing poor health status are increasing, while those experiencing good health status are decreasing. According to some experts, "socioeconomic, racial, and ethnic disparities in health status are *large, persistent*, and *ever increasing* in the United States." When elements of racism, poverty, and community environment converge, greater overall threats to health develop. Most communities and ethnic groups that experience disparate health status have worse outcomes than whites across a broad spectrum of illnesses, injuries and treatment outcomes.[1]

There are many factors that contribute to disparities in health. Some factors include: poverty, racial segregation, lower educational attainment, high unemployment, single parent households, limited access to care, lower quality housing, poorer environmental conditions, limited social opportunities, cultural differences, beliefs and norms, lack of language translation services, acculturation – seeking care and citizenship, lack of culturally diverse workforce, unfamiliarity with biomedicine, culturally insensitive providers, limited policies to address disparities, neighborhood context, nutritional differences, stress from discrimination, lack of hope, social support networks, mistrust, confidentiality, concentrated poverty, fragmentation of services, lower cost, lower quality medical care, provider bias/stereotyping, long waits and lack of transportation.[2]

National Data

Mortality Among Youth

Young adults ages 20-24 have a much higher mortality rate (95.2/100,000 youth) compared to youth ages 10-14 (19.5 per 100,000) and 15-19 (67.8 per 100,000).[3] Males are more likely to die than females.

- African American youth ages 15-24 have the highest mortality rate (125.2 per 100,000) followed by American Indian (117 per 100,000), Hispanic (85 per 100,000), white (72 per 100,000) and Asian/Pacific Islander (44.3 per 100,000).
- African American males ages 15-24 die at least 3 times as often as African American females (188.2 per 100,000 vs. 61.8 per 100,000).

- Hispanic males ages 15-24 die at 3.7 times that of Hispanic females (131.2 per 100,000 vs. 35.2 per 100,000).
- American Indian, white and Asian/Pacific Islander males ages 15-24 die at 2.4 times that of their female counterparts.

Unintentional Injury

Motor Vehicle Deaths

Motor vehicle crashes are the leading cause of death for adolescents and young adults: 31.7% of all deaths.**4**

American Indian male youth have the highest motor vehicle death rate (71.6 per 100,000) followed by white (37.2 per 100,000), Hispanic (34.5 per 100,000), black (23.6 per 100,000) and Asian/Pacific Islander (15.7 per 100,000). Males are twice as likely to die from motor vehicle crashes compared to females.

Seat Belt Usage

Seat belt usage varies by gender but not by race/ethnicity. Male high school students (82%) are less likely to wear a seat belt than females (90%).[5]

Violence

Homicide Rates Among Males (ages 15-19)

African American male homicide rates are twice as high as Hispanic male homicide rates (60.2 per 100,000 vs. 29.3 per 100,000) and 17 times as high for white males (60.2 per 100,000 vs. 3.4 per 100,000).[6]

Minority Confinement Rates

Although minority youth account for about one-third of the U.S. juvenile population, they comprise two-thirds of the juvenile detention/corrections population.[7]

Substance Use

Binge Drinking (ages 12-17)

American Indian/Alaska Native youth have the highest rate of binge drinking (12.8%) closely followed by white youth (12.1%). Hispanic (9.8%), African American (5.5%) and Asian/Pacific Islander youth (4.6%) had lower rates of binge drinking.[8]

Gender Disparities by High School Seniors

Males are more likely to use substances than females:

Substance	Males	Females
Cigarettes	26.2%	22.1%
Marijuana	24.7%	17.3%
Cocaine	2.6%	1.4%
Inhalants	2.0%	1.1%
Alcohol	71.7%	43.8%
Binge Drinking	34.2%	22.1%

Source: National Center for Health Statistics Chartbook, 2002.
www.cdc.gov/nchs

Mental Health

Suicide

Males ages 10-24 complete suicide at a rate over 5 times that of females whereas females attempt suicide more often (11% females vs. 6% males).[9]

American Indian/Alaskan Native youth ages 15-24 have the highest rates of suicide (27.9 per 100,000 for males and 7.4 per 100,000 for females) followed by white (17.7 per 100,000 for males and 3.1 per 100,000 for females), Hispanic (10.6 per 100,000 for males and 2.1 per 100,000 for females), African American (11.3 per 100,000 for males and 1.7 per 100,000 for females) and Asian/Pacific Islander youth (8.7 per 100,000 for males and 3.6 per 100,000 for females).[10]

Mental Health Services for Minorities

Minority youth have similar rates of mental disorders, but ethnic minority groups receive poorer quality mental health services and are less likely than whites to use services.[11]

Treatment patterns for minorities reflect under representation in outpatient care and overrepresentation in inpatient and emergency treatment.[12]

Reproductive Health

Birth Rates

Latino youth ages 15-19 have the highest rate of live births (83.4 per 1,000) followed by African American youth (68.3 per 1,000), American Indian/Alaska Native youth (53.8 per 1,000), white (28.5 per 1,000), and Asian/Pacific Islander (18.3 per 1,000).[13]

Chlamydia Rates

African Americans ages 15-19 have a much higher

rate of Chlamydia infections compared to American Indian/Alaska native, Hispanic, Asian/Pacific Islander and white youth. Females have a much higher rate than males.[14]

HIV/AIDS RatesEthnic minority youth ages 13-19 comprise more than 84% of new HIV infections.[15]

Chronic Disease

At-Risk for Overweight

African American high school female students (45.5%) and Hispanic high school male students (44.2%) have the highest rate of overweight followed by Hispanic females (43.5%), African American males (35.7%), white males (27.4%) and white females (25.4%).[16]

Tennessee Data

Mortality Data

The death rate for white youth ages 10 to 14 for 2001 was 22 per 100,000, compared to 26.1 per 100,000 for African American and 6.8 per 100,000 for all other races. The gap becomes wider with 15 to 19 year olds (81.1 per 100,000 versus 95 per 100,000 for white and African Americans respectively). The most dramatic difference is seen in 20 to 24 year olds. The death rate for white 20 to 24 year olds is 106.2 per 100,000 as compared to the astronomical rate of 200.9 per 100,000 for African American youth of the same age.

The difference in this age group can be contributed, in part, to the overwhelmingly high homicide rate in 20 to 24 year old African Americans. The homicide rate is more than six times higher for African American youth as compared to white youth ages 20 to 24.

For the most part the death rate for all other modes of death is similar; in fact accident and suicide rates are higher for white youth. The only other rate that African American death rates exceed that of white adolescents is the death rate associated with heart disease. It is the fourth leading cause of death among African Americans ages 20 to 24, at a rate of 10.8 per 100,000.[17]

Unintentional Injury

Motor Vehicle Deaths

Sixty percent of the young people ages 10-24 who died from motor vehicle crashes were white males, followed by 26% white females, 9% African American males, and 4% African American females.[18]

No data were identified that could describe current health disparities among young people ages 15-24 who died as a result of alcohol and drug related vehicle crashes.

Injury Prevention Behaviors

High school males (19.8%) are more likely to report rare or no use of seatbelts than are females (9.6%).

African American (37.2%) high school students were less likely to report always using a seat belt compared to white students (45%).

Ninth grade African American males (30.3%) are most likely to report the rare or lack of use of seatbelts.

White high school students (27.3%) are more likely than African American (24%) high school students to have ridden in a car driven by someone who had been drinking.

High school males (25.9%) and females (27.4%) equally chose to ride with a person who had been drinking.

African American high school females (23.6%) are the least likely to have ridden in a car with someone who had been drinking.[19]

Violence

Homicide Rates

African American males ages 10-24 are 15 times more likely to die from homicide than white males.

Homicide rates are significantly higher among the 20-24 age group (20.2 per 100,000) compared to the 15-19 age group (7.2 per 100,000) and the 10-14 age group (0.7 per 100,000).

There is a large gap between homicide rates for boys (62.6 per 100,000 in 2003) and girls (9.1 per 100,000 in 2003).[20]

Violent Behaviors

High school males (40%) were more likely than females (25%) to have been in a fight.

High school males were a little more than three times as likely to have been injured in a fight and need medical attention as females.

African American high school males (39%) were the most likely to have been in a fight compared to white males (36.5%), African American females (26%) and white females (16.7%).

White males (5.7%) are the most likely to have been injured in a fight, compared to African American males (3.8%), white females (1.5%) and African American females (0%).

High school males (8.6%) are 4 times as likely to carry weapons on school property compared to females (2.7%).

Many more white high school males (10.2%) report carrying a weapon on school property compared to African American males (2.3%).[21]

Partner Violence

Victimization of partner violence among high school teens is higher in African American teens (11.1%) than in white teens (9.2%).[22]

Substance Use

Binge Drinking

Many more white high school students (30%) report binge drinking compared to African American students (11%).[23]

Marijuana Use

African American high school males (55.1%) report more frequent marijuana use than white males (46%), African American females (39.6%) and white females (37.5%).[24]

Mental Health

Suicide

The suicide rate is highest among young adults ages 20-24 (13.6 per 100,000) compared to youth ages 15-19 (6.4 per 100,000) and 10-14 (1.5 per 100,000).

Males ages 10-24 complete suicide at rates approximately four times higher than females.

White males ages 10-24 (13.1 per 100,000) were almost 2 times more likely to die from suicide than African American males (7.9 per 100,000).[25]

More female high school students (17.7%) had made a suicide plan compared to males (10.6%).[26]

Reproductive Health

Birth Rates

The birth rate for African American females (20.2 per 100,000) ages 10-17 is twice the rate of white teens (9.7 per 100,000).

Of these females who gave birth, African American youth were fives times more likely to have not received prenatal care than white youth giving birth.[27]

In addition, African American females giving birth are twice as likely to have inadequate prenatal care as their white counterparts.[28]

Pregnancy Rates

Pregnancy rates for Tennessee's African American females ages 10-17 are two and one/half times higher than their white counterparts. The pregnancy rate for African American teens ages 10 to 17 is 27 per 100,000 compared to a rate of 12 per100,000 for white teens.

Another significant trend is that teen pregnancies among Hispanic youth are increasing whereas rates are decreasing for all other races.[29]

Low Birth Weight

Out of the 3,382 births to youth ages 10-17 during 2003, 389 or 11.5% were low birth weight. Young African Americans youth were more likely to have low weight birth babies (14.6 per 1,000) than young white youth (9.5 per 1,000).[30]

Single Parents

African American youth ages 10-17 (99%) had the highest rate of out-of- wedlock births followed by white youth (83.5%).[31]

Sexual Behaviors

Overall, the prevalence of having had sexual intercourse was higher among African American high

school students (67.3%) than white (41.8%) and Hispanic (51.4%) high school students.

The prevalence of having sex with 4 or more partners was higher among male (17.6%) than female (12.8%) high school students. Also, prevalence was higher among African American youth (23.5%) than white (12.6%) students. African American high school males (21.4%) were significantly more likely to have had sex with 4 or more partners than white males (13.3%).

African American high school males (19.1%) reported more than twice the likelihood to have engaged is sexual intercourse before age 13 than white males (8.2%).[32]

Infant Deaths

In 2003 there were more than twice as many infant deaths to young African American mothers ages 10-17 (291 infant deaths or 18 per 1,000) compared to young white mothers (424 infant deaths or 7 per 1,000).[33]

HIV/AIDS

As of June 2003 there were 472 Tennessee youth, ages 10 to 24 who were living with HIV/AIDS. Forty-one of those youth were ages 10 to 14. There are 49 infected youth in 15 to 19 year olds and 382 infected youth in 20 to 24 year olds. An overwhelming 76.9% of all youth infected are African American.[34]

Chlamydia Rates

In 2003 there were a total of 12,463 chlamydia cases reported for persons ages 10-24 in Tennessee. African Americans made up the majority of the cases (40%), followed by white youth (35%) and then other races (1%). A substantial number of the cases were unknown races (24%).[35]

Chronic Disease

Overweight

There are many more overweight high school males (20.7%) than females (9.5%) in Tennessee.

African American high school females (21.5%) are more than 3 times as likely to be overweight compared to their white female counterparts (6.3%).

More white high school males (21.2%) are overweight compared to African American males (18.3%).[36]

Addressing Health Disparities

For the most part disparities exist across all areas of health and health care. However, there are particular diseases or issues with respect to access and outcomes of treatment of such diseases that have much higher disparities, especially among African American populations. Studies that emerged in the late nineties illustrating the disparities that exist among racial and ethnic minorities prompted Congress to commission the Institute of Medicine (IOM) to assess the differences in the kinds and quality of health care received by U.S. racial minorities.

Congress specifically requested the Institute of Medicine to assess the extent of racial and ethnic differences in health care that are not linked to access to care issues, such as lack of health insurance; to evaluate potential sources of racial and ethnic disparities including the role of bias, discrimination, and stereotyping at the individual, institutional and health systems level; and to provide recommendations regarding interventions to eliminate health care disparities. The findings and recommendations provided by the Institute of Medicine's investigations follow.[37]

IOM Summary of Findings

- Racial and ethnic disparities in health care exist and, because they are associated with worse outcomes in many cases, are unacceptable.
- Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality and evidence of persistence racial and ethnic discrimination in many sectors of American life.
- Many sources, including health systems, health care providers, patients and utilization managers, may contribute to racial and ethnic disparities in health care.

- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care. While indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research.
- A small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully explain health care disparities.

IOM Summary of Reccomendations

General Recommendations

- Increase awareness of racial and ethnic disparities in health care among general public and key stakeholders.
- Increase health care providers' awareness of disparities.

Legal, Regulatory and Policy Interventions

- Avoid fragmentation of health plans along socio-economic lines.
- Strengthen the stability of patient-provider relationships in publicly funded health plans.
- Increase the proportion of underrepresented U.S. racial and ethnic minorities among health care professionals.
- Apply the same managed care protections to the publicly funded HMO enrollees that apply to private HMO enrollees.
- Provide greater resources to the U.S. DHHS Office for Civil Rights to enforce the civil rights laws.

Health System Interventions

- Promote the consistence and equity of care through the use of evidence-based guidelines.
- Structure payment systems to ensure an adequate supply of services to promote minority patients, and limit provider incentives that promote disparities.
- Enhance patient-provided communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice.
- Support the use of interpretation services where community needs exist.
- Support the use of community health workers.
- Implement multidisciplinary treatment and preventative care teams.

Patient Education and Empowerment

- Implement patient education programs to increase patient's knowledge of how to best access care and participate in treatment decisions.

Cross-Cultural Education in the Health Professions

- Integrate cross-cultural education into the training of all current and future health professionals.

Data Collection and Monitoring

- Collect and report data on health care access and utilization by patients' race, ethnicity, socioeconomic status, and primary language.
- Include measures of racial and ethnic disparities in performance measurement.
- Monitor progress toward the elimination of health care disparities.
- Report racial and ethnic data by Office of Management and Budget categories, but use subpopulation categories where possible.

Research Needs

- Conduct further research to identify sources of racial and ethnic disparities and assess promising intervention strategies.
- Conduct research on ethical issues and other barriers to elimination health disparities.

Best Practices in Eliminating Health Disparities

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.

State Level

The Commonwealth Fund produced ***A State Policy Agenda to Eliminate Racial and Ethnic Health***

Disparities report that provides the following priorities for states to use to build infrastructure and capacity to address health disparities:

Cultural and linguistic competency

States can develop standards tailored to community needs, collect data to identify service needs, finance interpreter services, and increase the supply of minority health providers.

Data

States have a critical role in fostering collection, analysis, and use of minority health data for the identification and amelioration of disparities. Some state surveillance systems' racial and ethnic classifications, however, are very narrow. Some states still categorize all racial and ethnic groups as black or white only. The accepted national standard for data collection is the race and ethnicity categories in the Office of Management and Budget's Directive 15.

Insurance coverage

More than half of U.S. uninsured belong to racial and ethnic minorities. For them, Medicaid and State Children's Health Insurance Programs make available important and otherwise unobtainable coverage. States should expand eligibility, encourage enrollment, and eliminate administrative obstacles to promote wider coverage.

Primary care

States can expand the number and capacity of community health centers, reduce financial barriers to obtaining primary care, and increase research efforts to address disparities in primary care for minority populations.

Purchasing

States can use their extensive purchasing power to require data collection and reporting, mandate consumer satisfaction surveys, and require specific health interventions.

Regulatory approaches

States can influence professionals, institutions, and health plans by using licensure and other regulatory requirements to address provider and facility shortages in minority communities.

State infrastructure

States can help minority health offices reduce disparities by ensuring that these offices have adequate financial resources (many are channeling revenue from the Tobacco Settlement), limit staff turnover, foster good relations with other state agencies, legislative and/or regulatory grounding, access to data, and clear performance measures.

Workforce development

States can foster a more diverse health workforce by diversifying applicant pools, developing incentive programs, ensuring adequate data collection, and using Graduate Medical Education funds more creatively.

Involve all health system stakeholders

Issues related to minority health and health disparities can be easily pigeon-holed so that policymakers have only limited exposure to them. Yet any effective strategy requires the full engagement of state governments — including executive and legislative branch leaders — and the broader health sector — including hospitals, physicians, community health centers, nurses, home health providers, the public health community, community-based organizations, and more. An effective strategy must also engage the broader public through community-based public education activities and programs.[38]

Program Level

Programs can strive to address health disparities by assuring that their organization/staff are culturally competent. Cultural competence at the organizational level is not solely a program or initiative. Instead, it is a commitment that is widely shared among program board members and staff, and reinforced in all aspects of policy development, program management, and

service delivery. Those organizations that are culturally competent generally share a common set of values that includes:

- Understanding and accepting the diverse cultures represented in the community;
- Recognizing the social, political, and economic climates of the community within cultural contexts;
- Honoring the inherent ability of communities to recognize their own problems and intervene appropriately on their own behalf;
- Sharing limited resources effectively and equitably among competing needs;
- Sharing power with the community and ensuring that the contributions of community residents are valued and respected; and
- Providing community residents with full and timely access to information.

How these values are embedded in the policies and programs of culturally competent organizations is based on their unique communities, strengths, and organizational structures.

While there is not an approach that is universally best, there are a number of strategies that have been used successfully by organizations to develop their capacities to work effectively with diverse groups within their communities. Some examples include:

- Integrating awareness of and sensitivity to diverse community residents in organizational policies and procedures;
- Involving representative groups of community residents in a meaningful way in the planning and program development processes;
- Conducting organizational self-assessments of the level of cultural competency among Board members and staff;
- Developing performance objectives for outreach and service to diverse community groups, and measuring progress towards their attainment;
- Recruiting and retaining Board members that are representative of the population of the organization's target area;
- Employing program and management staff throughout the organization that are reflective of the diversity within the community; and
- Offering staff and Board members opportunities for participation in professional development activities related to diversity and cultural competence.[39]

Tennessee's Health Disparities Prevention Programs

Tennessee Office of Minority Health (OMH)

The Tennessee Office of Minority Health (OMH) was established in 1994 and serves as a central point for the Department of Health on minority health issues. The OMH engages in projects providing essential leadership to address major public health needs. Collaborative efforts include community outreach, education, seminars and health promotion campaigns. Strategies of the Office of Minority Health include:

- Facilitate coalitions directed toward healthy communities
- Support recruitment and retention of minority health professionals
- Promote policies that improve minority health
- Emphasize improvement and focus of minority health research data
- Develop and allocate resources for health programs
- Encourage recognition of health issues of special populations not traditionally considered, i.e., elderly, women, poor
- Monitor legislative activity on issues with direct impact on minority health
- Collaborate with established associations to enhance minority health initiatives, e.g., diabetes, cancer, family issues, rural health

For more information about the Office of Minority Health programs, access their website at http://www2.state.tn.us/health/minorityhealth/index.html.

Tennessee Department of Health's "Better Health: It's About Time" Initiative

The goal of Better Health: It's About Time initiative is to raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well-being, and to give newborn babies a better start in life.

Healthy lifestyle choices, including regular exercise, a nutritious diet, giving up tobacco use, and getting preventive health care, can help you live a longer, healthier life. Factors such as maternal smoking, drug and alcohol abuse, poor nutrition, stress, inadequate prenatal care, and chronic illness also affect whether babies are born healthy.

For more information about the Better Health: It's About Time initiative, access their website at http://www.tennessee.gov/health/itsabouttime/index.htm.

Tennessee Black Health Care Commission

In response to growing concerns for African American communities through-out the state, the Tennessee Department of Health established the Tennessee Black Health Care Commission. In collaboration with the Tennessee Office of Minority Health, a comprehensive plan *(Eliminating Health Disparities for African Americans in Tennessee)* was developed. This plan discusses health disparities among the African American communities across the state. Since most of the disparities pertain to adult diseases, much of the focus is upon adult African Americans. However, most of the diseases that African Americans disproportionally suffer are manageable with good health practices. Many of these problems will affect our present adolescent population when they become adults if health interventions are not successful during their youth.

End Notes

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Ten Critical Tasks for Improving Adolescent and Young Adult Health in Tennessee

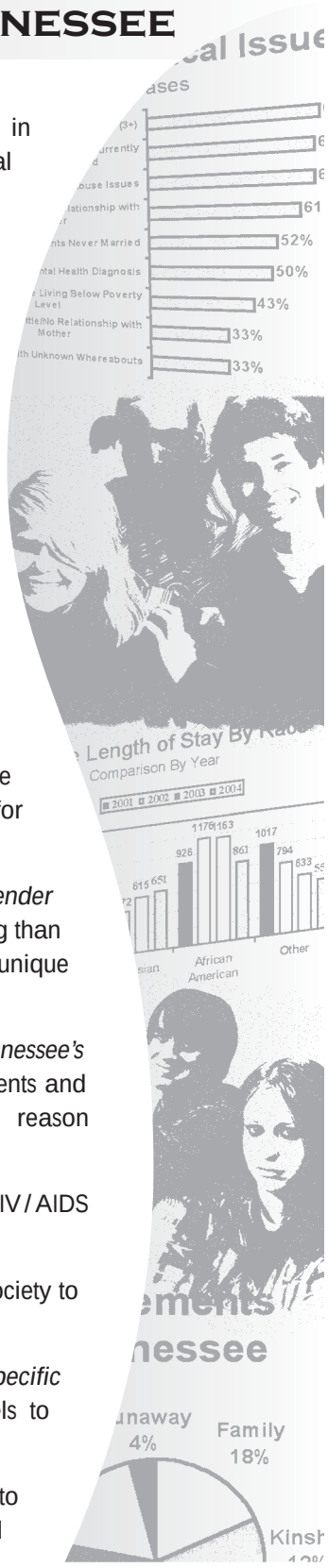
This chapter outlines ten critical tasks to improve adolescent and young adult health in Tennessee. The tasks include steps that can be taken by individuals, families, schools, local government, the private and non-profit sectors, faith-based organizations, policymakers, and young people themselves.

The Vision

The vision of the *Tennessee Initiative to Improve Adolescent and Young Adult Health by 2010* is to develop and strengthen partnerships at all levels of society that promote the health and well-being of Tennessee's youth. Particular emphasis should be on addressing health disparities, positive youth development, prevention, risk reduction and early intervention.

Ten Action Steps

1. *Ensure Access to Mental Health Services:* Assure availability of services for early identification and intervention with at-risk adolescents.
2. *Support Parents in Effective Parenting of Adolescent Children:* Help families to reach their potential as irreplaceable positive influences in the lives of teens.
3. *Develop dedicated funding for adolescent health:* In order to adequately address the multiple needs of "at risk" adolescents and young adults, dedicated funding for adolescent health should be established.
4. *Address health disparities among adolescents and young adults with a focus on gender issues:* Male adolescents and young adults often report higher degrees of risk-taking than females. However, few policies and programs are designed to meet young men's unique needs.
5. *Ensure/Improve access to health services with an emphasis on promoting Tennessee's confidentiality laws:* Assure the availability of health services for "at-risk" adolescents and young adults. Also, address confidentiality issues since the most common reason adolescents do not access preventive health care is confidentiality concerns.
6. *Maintain reproductive health as a priority:* Focus on reducing teen pregnancy, HIV/AIDS and sexually transmitted diseases among adolescents and young adults.
7. *Build/strengthen partnerships outside of public health:* Partner with all sectors of society to address adolescent and young adult health issues.
8. *Develop a uniform statewide data collection system that would provide county specific data:* Uniform data is needed by county as well as by region and state levels to determine program priorities and resource allocation.
9. *Build public support for investment in youth:* A great deal is known about how to address the opportunities for positive youth development and to reduce the potential



for adverse consequences of adolescent risk-taking. Adequate long-term investment will always be required, and the voting public must see the purpose and value of investing its scarce resources.

10. *Involve Youth in Policy Formation and Program Implementation:* Use teens' firsthand knowledge of school, peer and community environments in forming policies that impact youth.